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In connection with the publication of DSM-IV, it is of interest to compare the diagnosis of posttraumatic stress disorder (PTSD) as defined in DSM-IV with its definition in DSM-III-R and in ICD-10. Although there are great similarities in the different diagnostic systems, there are also important differences, particularly between the DSM systems and the ICD system, which does not attach the same emphasis to avoidance and the hyperarousal as do the DSM systems.

☐ *DSM-III-R, DSM-IV, ICD-10, Posttraumatic stress disorder, Trauma.*

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What is now known as posttraumatic stress disorder (PTSD) was called "gross stress reaction" in the first edition of the DSM (1) and "transient situational disturbance" in DSM-II (2). However, the changing terminology reflects differences in diagnoses. All three diagnoses are similar inasmuch as the syndrome represents a response to overwhelming environmental stress, but whereas in DSM and DSM-II the diagnosis was confined to acute stress reactions occurring in individuals without prior or simultaneous disorders, in DSM-III (3) the diagnosis included not only chronic stress reactions but also their occurrence in individuals with previous or concurrent disorders. The diagnosis PTSD has thus evolved from an acute reaction in putatively healthy individuals to a syndrome occurring as an acute or chronic response with or without previous and/or concurrent pathologic condition (4).

A brief evaluation

In a review by Blank (5) the natural history of PTSD was said to vary with regard to the time of symptom onset and the duration of the course and also the type and variation of intrusive and avoidant symptoms and the existence of subclinical PTSD. Rothbaum & Foa (6) reported the rate of spontaneous remission to be high, occurring predominantly in the early months after the trauma, but found no relationship between adjustment reactions and PTSD.

In a review of PTSD and criminal victimization (7), Kilpatrick & Resnick singled out six important aspects: specificity of symptoms to the trauma; prevalence of exposure to criminal victimization in the community; differences in rates of crime-induced PTSD across various sample populations, differing from each other in duration of symptoms; effect of crime type and other factors on the prevalence of PTSD; and psychiatric comorbidity and the frequency of individual symptoms and patterns of co-occurrence. The collected findings of their review suggest not only that criminal victimization is manifestly within the range of normal human experience but also that it is associated with high rates of PTSD. The findings also indicate that other more commonly experienced events may well be subjectivly interpreted as threatening or stressful by those who experience them (7). March (8), who formulated DSM-IV criterion A, stresses the importance of considering whether an event is traumatic. We still lack the empiric information necessary to decide how subjective perception should be reconciled with objective descriptions or how to ascertain PTSD risk due to events of

lesser magnitude. The DSM-IV criterion A – that is, the trauma criterion – enables the subjective features to be considered by the specifying perceptual correlates of typical PTSD-inducing events.

Davidson & Fairbank (9), who reviewed studies of the epidemiology of PTSD, have grouped those affected into high-risk groups, such as combat veterans and disaster victims, and non-high-risk groups. They also emphasized the uniqueness of PTSD in differing fundamentally from other major disorders in its relationship to a traumatic event.

Interest in biologic findings has increased enormously during the past decade (10, 11), especially with regard to use in guiding proper classification and suggesting the need for any revision of diagnostic criteria. Neuroendocrine and neurophysiologic studies have yielded results showing PTSD to be associated with a disturbance in the hypothalamic-pituitary-adrenal axis reflected in high levels of adrenaline/noradrenaline in blood and low levels of cortisol in urine, a pattern clearly differing from that in other acute stress reactions or in depression. So far this pattern seems to be unique to PTSD. The criteria according to PTSD are listed in the recently released fourth version of DSM (12) (Table 1).

A comparison

According to DSM-III-R, to fulfil the diagnosis PSTD, five criteria must be satisfied: the presence of a preceding traumatic experience, intrusion, avoidance, arousal, and a duration of at least 1 month. To be able to analyse the differences between the DSMIII-R, DSM-IV, and ICD-10 (13), we need to consider the criteria one by one.

Criterion A, as formulated in DSM-III-R, requires that the individual has experienced an event that is outside the range of usual human experience, and which would be manifestly distressing to almost everyone, such as a serious threat to one's life or integrity, a serious threat to one's spouse, children, or other relatives or friends, sudden destruction of one's home or community, or witnessing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In DSM-IV the requirements have been completely reformulated and comprise two items. First, the person must have experienced, witnessed, or been confronted with an event involving actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. At first glance there seems to be a difference between these two criteria. In DSM-IV the formulation "confronted with" can be understood as seeing, experiencing, or learning about, and the latter alternative, learning about, is not mentioned in the DSM-III-R criteria. However, closer scrutiny of the explanations in the DSM-III-R text shows that "in some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g. that one's child has been kidnapped". Thus, the single remaining difference between these two is that DSM-III-R refers to relatives and close friends, whereas DSM-IV refers to "oneself or others" – that is, anyone. The second item mentioned in DSM-IV is that the person's response involves intense fear, helplessness, or horror. This reaction is not mentioned in DSM-III-R but might be considered to be implied.

Even though the ICD-10 criteria have not been subdivided in the same way as those of DSM, the corresponding ICD-10 requirement is manifestly comparable to DSM criterion A. ICD-10 describes a stressful event of an exceptionally threatening or catastrophic nature, likely to cause pervasive distress in almost everyone, and the formulation includes witnessing the violent death of others. So far the ICD text is closer to that of DSM-IV, but even though the requirement of the person's response (intense fear, helplessness) is not the same as in DSM-III-R, it might be considered to be implied.

DSM-III-R criterion B consists of different ways of reexperiencing the trauma, such as recurrent and intrusive recollections, dreams, sudden acting or feelings as if the event were recurring, and intense psychologic distress at exposure to events that symbolize or resemble the traumatic event. DSM-IV adds physiologic activity on exposure to events, internal or external, that symbolize or resemble the traumatic event. This item has been labelled the D criterion in DSM-III R. ICD-10 mentions intrusive memories or dreams. Consequently, the B criterion may be considered to be in good agreement with the corresponding ICD-10 requirement.

The DSM C criterion concerns avoidance and is identical in the two editions. This criterion

Table 1. The DSM IV criteria for posttraumatic stress disorder.

A. The person has been exposed to a traumatic event in which both of the following have been present:
   1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
   2. The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   1. Recurrent and intrusive distressing recollections of the event.
   2. Recurrent distressing dreams of the event.
   3. Acting or feeling as if the traumatic event were recurring.
   4. Intense psychologic distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
   5. Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
   1. Efforts to avoid thoughts, feelings.
   2. Efforts to avoid activities, places, or people.
   3. Inability to recall an important aspect of the trauma.
   4. Markedly diminished interest or participation in significant activities.
   5. Feeling of detachment or enstrangement from others.
   6. Restricted range of affect (for example, unable to have loving feelings).
   7. Sense of a foreshortened future.

D. Persistent symptoms of increased arousal as indicated by at least two of the following:
   1. Difficulty falling or staying asleep.
   2. Irritability or outburtsts of anger.
   3. Difficulty concentrating.
   4. Hypervigilance.
   5. Exaggerated startle response.

E. Duration (symptoms in B, C, and D) more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months.
Chronic: if duration of symptoms is 3 months or more.
Specify if:
With delayed onset: if onset of symptoms is at least 6 months after the stressor.

represents efforts to avoid thoughts or feelings associated with the trauma, activities, or situations that arouse recollections, psychogenic amnesia, diminished interest in significant activities, feeling of detachment from others, and a restricted range of affect and sense of foreshortened future. The wording differs somewhat in ICD-10. In ICD-10 "detachment from others" means an effort to avoid reminders of the trauma. The "restricted range of affect" has been defined "numbness" or emotional blunting in ICD-10. In ICD-10 no mention is made of efforts to avoid thoughts or feelings associated with the trauma, nor is there any mention of psychogenic amnesia or the sense of foreshortened future. Instead, ICD-10 stresses mood disorders such as depression and anxiety, which might be seen as a parallel to the diminshed interest in significant activities mentioned in the DSM system and also perhaps to the sense of foreshortened future.

DSM-III-R criterion D deals with such hyperarousal phenomena as sleep disorders, irrita-

bility, and outbursts of anger, difficulties in concentrating, hypervigilance, exaggerated startle response, and physiologic reactivity on exposure to events that symbolize or resemble an aspect of the traumatic event. The latter item has in DSM-IV been reassigned to criterion B, as mentioned above. In ICD-10 we also find autonomic hyperarousal mentioned with insomnia, hypervigilance, and enhanced startle response and with bursts of fear or anger, triggered by stimuli resembling the trauma.

DSM-III-R ends with criterion E, which defines the duration of the disturbance as being at least 1 month and specifies delayed onset if it occurs more than 6 months after the trauma. DSM-IV also specifies acute PTSD as a duration of symptoms of less than 3 months, and chronic PTSD as a duration of symptoms of 3 months or more. ICD-10 stipulates that the disorder should not generally be diagnosed unless there is evidence that the onset of symptoms occurs within 6 months of a traumatic event but suggests that if the delay in onset is more than 6 months, the diagnosis might still be appropriate if the symptoms are typical.

DSM-IV adds another criterion, the F criterion, which specifies significant distress or impairment in social, occupational, or other important areas of functioning.

The concept of DESNOS (disorders of extreme stress not otherwise specified) has been under consideration for inclusion in DSM-IV (14). DESNOS have been descibed as more complex types of posttraumatic stress reactions, occurring characteristically in victims of prolonged, repeated interpersonal violence or victimization. This concept was not included in the final version of DSM-IV, however.

Another important improvement in DSM-IV is the introduction of a new diagnostic category, acute stress disorder, which is appropriate only when symptoms occur within 1 month of the extreme stressor, and for cases that do not satisfy the criteria for adjustment disorder or PTSD. The acute stress disorder must also be distinguished from the following: mental disorder due to a general medical condition; substance-induced disorder; brief psychotic episode; major depressive episode; exacerbation of a preexisting mental disorder; and malingering.

Unlike the DSM editions, ICD-10 mentions such predisposing factors as personality traits or a history of neurotic illness, either of which may lower the threshold for the development of the syndrome or aggravate its course.

ICD-10 also includes a long-term outcome: enduring personality change after catastrophic experience. To be considered appropriate, this personality change must have been present for at least 2 years, and should not be attributable to a preexisting personality disorder. The diagnostic criteria for this personality change are as follows: a hostile or mistrustful attitude towards the world; social withdrawal; feelings of emptiness or hopelessness; a chronic feeling of being "on edge", as if constantly threatened; and estrangement.

Conclusions

For a diagnosis of PTSD, according to DSM-III-R, criterion A has to be fulfilled and at least one of the B criteria, three of the C criteria, two of the D criteria, and the E criterion. According to DSM-IV, PTSD has a somewhat different A criterion, in which there is no demand that the person should, in any way, have any personal relationship to the person(s) involved in the trauma he has witnessed (if the injury has happened to anyone but the person himself), and it also clearly states that the stressful event should induce intense fear or helplessness. DSM-IV also stresses functional impairment as essential for the diagnosis. ICD-10 differs somewhat more from the two DSM editions: a preceding trauma is necessary, and there must also be a repetitive, intrusive recollection or reenactment of the event – that is, in accord with the DSM requirements of criteria A and B. All other previously mentioned symptoms are required for a diagnosis of the syndrome according to DSM, but are not essential for a diagnosis acccording to ICD-10.

The importance of a correct diagnosis cannot be overestimated. Apart from a purely scientific point of view, a diagnosis is naturally of great importance to the patient. It is usually a great relief to any patient to be given a name for his symptoms, to understand the mechanisms, and to learn that PTSD is not only a known but also a common reaction to psychologic trauma. There may also be economic interests in establishing the diagnosis, especially when accidents with claims for damages or indemnity are involved.

Asylum application is another issue in which the diagnosis might be of great importance.

Associated features such as other psychiatric disorders – for example, anxiety and depressive disorders – are common and will naturally require treatment. Drug abuse, especially alcohol abuse, is commonly used by the patient as an attempt at self-treatment or as a buffer against unbearable agony. The frequency of a somatization tendency is quite high, perhaps due to the alexithymic symptoms as a result of the emotional blunting. The specificity of the symptoms also requires specificity in treatment. Generally, the patient does not get well merely as a result of the different psychotherapeutic methods (15), but also needs psychopharmacologic treatment. Selective serotonin reuptake inhibitors (SSRI) seem to be quite effective in treating some of the symptoms associated with PTSD (16–20).

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